

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

## CERTIFICATE OF DEATH

05236  
Reg. Dist. No. 833

## 1. PLACE OF DEATH:

County Princeton  
City or town Princeton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

P.O. #2, Princeton Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Princeton  
City or town Princeton  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. P.O. #2, Princeton Md  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mannie Adkins

## 3. (b) Social Security Number

4. Sex Female 5. Color or age White 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Frank Adkins6. (c) If alive, give age Dead years7. Birth date of deceased (mo., day, yr.) Aug. 17-18848. AGE: Years 61 Months 8 Days 17 hrs. min.9. Birthplace Princeton G. Md.  
(Town, county, and state)10. Usual occupation House wife11. Industry or business at home12. Name John Sampson Simmons13. Birthplace Princeton G. Md.14. Maiden name Joanna Simmons15. Birthplace Princeton G. Md.16. Informant Mr. James P. AdkinsAddress P.O. #2, Princeton Md17. Burial May 1946

(Burial, cremation, or removal. When?) Date thereof (month) (day) (year)

Cemetery or crematory St. John'sLocation San Antonio Maryland18. Funeral director Hollings & G. Walter R. HollingsAddress Salisbury Maryland19. 57/7/46

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 4<sup>th</sup> 1946 at 450P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946 to day of death and that I last saw him alive on May 3rd 1946 1946Immediate cause of death Carcinoma of middle ear  
right side.

Due to

Due to

Other conditions for interstitial nephritis  
hypertension  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Frank R. Lewis M.D.Address Bellevue MarylandDate signed 5/6/46

M. D. or other

Address Bellevue MarylandDate signed 5/6/46

RECEIVED

MAY 11 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

## CERTIFICATE OF DEATH

05237 330  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County NeocombsCity or town Mandela  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifetimeHospital, institution, or street address where death occurred:  
P.O. #1.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County NeocombsCity or town Mandela  
(If outside city or town limits, write RURAL and give nearest town)Street No. P.O. #1.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Earl John Alexander

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ratie Campbell Alexander

7. Birth date of deceased (mo., day, yr.)

May 8<sup>th</sup> 18686. (c) If alive, give age 58 years

8. AGE:

Years

Months

Days

If less than one day

78012hrs.min.

9. Birthplace

P.O. Mandela Maryland  
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

John Alexander

13. Birthplace

England

14. Maiden name

Mary Emily Nicholas

15. Birthplace

P.O. Salisbury Maryland

16. Informant

Mrs. Florence Addicks

Address

E. College Ave., Salisbury Md.

17.

(Burial, cremation, or removal, which?)

Date thereof

May 23, 1946  
(month) (day) (year)

Cemetery or crematory

Walter Baptist Cem.

Location

P.O. #1 Mandela Md.

18. Funeral director

Hollings G. Walter R. Hollings

Address

Salisbury Maryland

19.

5/22/46

19

46W. H. Robertson

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 20<sup>th</sup> 19 46 at 5:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him on May 20<sup>th</sup> 1946

Immediate cause of death

coronary occlusion

DURATION

sudden death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Sakadenabr M.D.  
Deputy Medical Examiner

M. D. or other

Address

Salisbury Md.Date signed 5/20/46

RECEIVED

MAY 23 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

05238

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County SalisburyCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 yearsHospital, institution or street address where death occurred: 506 Tilghman St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State MD County McComieCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. 506 Tilghman  
(If rural give LOCATION)2. (a) If veteran, name was Griffin Amick

## 3. (a) FULL NAME

Charles Lee Bailey

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Louise E. Bailey

## 7. Birth date of deceased (mo., day, yr.)

April 9-18806. (c) If alive, give age 48 1/2 years

## 8. AGE:

Years 66 Months — Days 24 If less than one day  
hrs. min.

## 9. Birthplace

Georgetown Del.  
(Town, county, and state)

## 10. Usual occupation

Shut Linner

## 11. Industry or business

at Laundry

## 12. Name

Charles Bailey

## 13. Birthplace

Salisbury Md.

## 14. Maiden name

Emma Dyke

## 15. Birthplace

Salisbury Md.

## 16. Informant

Mrs. Louise E. Bailey

## Address

506 Tilghman St. Salisbury Md.

## 17. Burial

Salisbury Md.  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year) May 6-46

## Cemetery or crematory

Salisbury Maryland

## Location

Salisbury Md.

## 18. Funeral director

Walter R. Bailey

## Address

Salisbury Maryland

## 19. Date rec'd by registrar

5-16-46

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

May 3-46 1946 at 12:15 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

to 10 minutesand that I last saw him alive on May 3-46 at Salisbury

Immediate cause of death

Coronary occlusion

## DURATION

Sudden death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Autopsy result

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

John Rademaker MD  
Deputy Med

M. D. or other

Address Salisbury Date signed 5/16/46

100-50

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

RECEIVED  
MAY 9 1946  
BUREAU V. R.

*Remitted*  
ANTHONY J. S. L. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B42)

## CERTIFICATE OF DEATH

05239

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Sevenside General Hospital

How long in hospital or institution?

3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County WicomicoCity or town Salisbury md  
(If outside city or town limits, write RURAL and give nearest town)Street No. 112 North  
(If rural, give LOCATION)

2.(a) If veteran, name war

no

## 3. (a) FULL NAME

Baker Hattie

## 3. (b) Social Security Number

213-24-0515

## 4. Sex

Female

## 5. Color or race

C

## 6. (a) Single, married, widowed, or divorced

Single

## 8. (b) Name of husband or wife

Johnnie Lee Baker

## 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Die 22 1900

## 8. AGE:

Years

Months

Days

If less than one day

46 5 8 ..... hrs. .... min.

## 9. Birthplace

O. Kellar Florida  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

Same as above

## 12. Name

Peter Smith

## 13. Birthplace

Bluefield W. V.

## 14. Maiden name

Katie Smith

## 15. Birthplace

O. Kellar Florida

## 16. Informant

John Lee Baker

## Address

Salisbury md

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

May 4 - 1946  
(month) (day) (year)

## Cemetery or crematory

Horton

## Location

Salisbury md

## 18. Funeral director

Jessie H. Stewart

## Address

Salisbury md

## 19. Date rec'd by registrar

5-14-46 Barry L. Johnson Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 - 1946 at 11:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw her alive on May 1st 1946 19.....Immediate cause of death Uræmia DURATION

.....

.....

.....

Due to Tuberculosis of Kidneys

.....

Due to Tuberculosis of Lungs

.....

Other conditions Calcium both

.....

Kidneys - a plastic aneurysm

(Include pregnancy within 3 months of death)

Major findings of operations Blockage of both uretersby Calcium deposits Date of opkidney done by tubercular

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Currie J. Henry M. D. or otherAddress 303 W. Church St. Date signed Salisbury

550

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RECEIVED

RECEIVED

MAY 10 1946

BUREAU V.E.

RECEIVED

MAY 10 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County SalisburyCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
P.B. Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State MD County McComi CoCity or town Killbuck  
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D. #2  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Mabel Baker

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Purton E. Baker6. (c) If alive, give age 40 years

## 7. Birth date of deceased (mo., day, yr.)

Aug. 23<sup>rd</sup> 1909

## 8. AGE:

Years 36 Months 8 Days 27 If less than one day

## 9. Birthplace

R.D. Killbuck Md.  
(Town, county, and state)

## 10. Usual occupation

Home wife

## 11. Industry or business

at home

## 12. Name

Ida Wilkins

## 13. Birthplace

R.D. Killbuck Md.

## 14. Maiden name

Ida Wilkins

## 15. Birthplace

R.D. Killbuck Md.

## 16. Informant

M. Purton E. Baker

## 17. Address

R.D. #2 Killbuck Md.

## 18. Burial

Buried

## 19. Date thereof

May 23<sup>rd</sup> 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

## 20. Cemetery or crematory

New Hope Ch.

## 21. Location

New Hope Ch.

## 22. Funeral director

John W. C. Walter & Son

## 23. Address

Salisbury Maryland

## 24. Date signed by Registrar

5/23/46

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 20<sup>th</sup> 1946 at 6 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 15 1946 to May 20 1946and that I last saw him alive on May 19 1946

Immediate cause of death

Chronic glomerular nephritis

DURATION

5 yrs?

Due to

Due to

Other conditions

Hypertension  
marked edema  
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank R. Lewis M.D.  
Killbuck, Md.

M. D. or other

Date signed 5-20-46

RECEIVED  
MAY 24 1946  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Thiomis  
 City or town Salisbury, Md. P.D. 1.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 weeks  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? ✓

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Thiomis  
 City or town Salisbury, Md. P.D. 1  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ✓  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Joseph Carroll

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower  
 6. (b) Name of husband or wife ✓ Mary C. Carroll  
 7. Birth date of deceased (mo., day, yr.) Nov. 3, 1870. 6. (c) If alive, give age 75 years

8. AGE: Years 75 Months 6 Days ✓ If less than one day  
 hrs. min.

9. Birthplace Thiomis Co., Md.  
 (Town, county, and state)

10. Usual occupation Scholar (Retired)

11. Industry or business Mobile Groceries

12. Name William Carroll

13. Birthplace Maryland

14. Maiden name Mary Etta Holland

15. Birthplace Maryland

16. Informant Mrs. Mildred Repton

Address Salisbury, Md.

17. Burial Date thereof 5/8/46  
 (Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Parsons

Location Salisbury, Md.

18. Funeral director De Will & Brown Co.

Address Salisbury, Md.

19. 6-18 19 46 Registrar John H. H. H.

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1946 at 8:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18, 1946 to May 5, 1946  
 and that I last saw him alive on May 5, 1946

Immediate cause of death Cerebral Hemorrhage DURATION

Due to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John H. H. H. M. D. or other

Address 238 Cambridge Date signed May 5, 1946

MAY 11 1946

BUREAU V. R.

PG hosp. statement, relayed by Dr. A.W. Hedrich 7-15-46.

See FILE 7-15-46, DR. HEDRICH, LL

2411 N. Charles St., Baltimore 1702

CERTIFICATE OF DEATH

Reg. Dist. No. 0524868

1. PLACE OF DEATH:

County Somerset City or town Princess Anne Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 1/2 hrs.  
Hospital, institution, or street address where death occurred:

P. G. HOSPITAL

How long in hospital or institution? 1 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)  
State Maryland County Somerset

City or town Princess Anne Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war none

3. (a) FULL NAME

Orrick James Carey

3. (b) Social Security Number

214-12-5271

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Sula H. Carey

7. Birth date of deceased (mo., day, yr.) January 23, 1881

8. AGE: 65 Years 5 Months 1 Days 60 hrs. 0 min.

9. Birthplace Princess Anne, Somerset, Md.  
(Town, county, and state)

10. Usual occupation Brother

11. Industry or business Produce Broker

12. Name James A. Carey

13. Birthplace Princess Anne Md.

14. Maiden name Angeline Powell

15. Birthplace Princess Anne Md.

16. Informant Mrs. Sula Carey

Address Princess Anne Md.

17. Burial Date thereof May 3, 1946  
(Burial, cremation, or removal, Which?) (month, day, year)

Cemetery or crematory Presbyterian Cemetery

Location Princess Anne Md.

18. Funeral director Charles D. Ashwell

Address Princess Anne Md.

19. June 3 '46 R. H. Johnson, M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1946 at 10:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 to 1946 and that I last saw him live on 1946

Immediate cause of death Fractured spine

Other conditions \_\_\_\_\_

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/31/46

Where did injury occur? Princess Anne Somerset Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public place

Means of injury Silly auto Injured at work? No

23. SIGNATURE Henry M. Louckford, M.D. M. D. or other

Address Princess Anne Md Date signed 6/3/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED

JUN 4 1946

BUREAU V B

NOTE: MICROFILM NOT WORKING TODAY;  
being used by other people. LL

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 181

05243

## CERTIFICATE OF DEATH

Reg. Dist. No. 999

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 6 days

## 3. (a) FULL NAME

Elizabeth Cole

## 4. Sex

F

## 5. Color or race

C

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Louis Cole

## 7. Birth date of deceased (mo., day, yr.)

Unknown

## 5. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years 36

## Months

## Days

## If less than one day

hrs.

min.

## 9. Birthplace

Richmond, Virginia  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

## FATHER

## 12. Name

Unknown

## 13. Birthplace

## MOTHER

## 14. Maiden name

Unknown

## 15. Birthplace

Edward Cole

## 16. Informant

Rural Pocomoke Md

## Address

Burial

## 17. (Burial, cremation, or removal, which?)

Date thereof May 12-1946  
(month) (day) (year)

## Cemetery or crematorium

St James Cemetery

## Location

Rural Pocomoke Md

## 18. Funeral director

Henry H. Wadsworth

## Address

Pocomoke Md

## 19.

6-7-14, 1946

(Date rec'd by registrar)

19.46

Warrick E. SmithState

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Pocomoke City  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

## 2. (a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number \_\_\_\_\_

## MEDICAL CERTIFICATION

2D. DATE OF DEATH May 11 1946 at 5:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19\_\_\_\_ to 19\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on 19\_\_\_\_

## Immediate cause of death

Superficial lacerations over  
upper body

## DURATION

5 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5/11/46Where did injury occur? Pocomoke City Worcester Md  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury Injured by fire Injured at work? yes

## 23. SIGNATURE

John A. Riley M.D. and ExamAddress Worcester Md Date signed 5/11/46

RECEIVED

MAY 18 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(1312)

05244

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Wisconsin  
 City or town Salisbury  
 (If outside city or town limit, write RURAL and give nearest town)  
 How long in above place of death? 52 years  
 Hospital, institution, or street address where death occurred:  
231 Newton St  
 How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Mad County Wisconsin  
 City or town Salisbury  
 (If outside city or town limit, write RURAL and give nearest town)  
 Street No. 231 Newton St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Amelia Elizabeth Dashiell

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife William F. Dashiell  
 7. Birth date of deceased (mo., day, yr.) April 10, 1864 6.(c) If alive, give age ..... years  
 8. AGE: Years 82 Months 1 Days 14 If less than one day ..... hrs. .... min.

9. Birthplace Chance, Somerset co. Md  
 (Town, county, and state)

10. Usual occupation at home

## 11. Industry or business

FATHER 12. Name Elsha Piggins  
 13. Birthplace Croftfield, Somerset co. Md  
 MOTHER 14. Maiden name Mary Kate Tiquin  
 15. Birthplace Alexandria, Va.

16. Informant Wm P. Dashiell  
 Address Salisbury, Md

17. Burial Burial Date thereof 5/26/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parsons cemetery  
 Location Salisbury, Md

18. Funeral director The Hill's Pharmacy  
 Address Salisbury, Md

19. 6-26-46 19 46 Harriet E. Johnson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 19 46 at 2:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938 May 28 19 46  
 and that I last saw him alive on May 24 19 46

Immediate cause of death Chronic nephritis DURATION 8 yrs  
Chronic nephritis 8 yrs

Due to .....

Due to .....

Other conditions Hypertension 6 yrs

(Include pregnancy within 3 months of death)

Major findings of operations .....

..... Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injured at work?

23. SIGNATURE James R. Mann

M. D. or other Dec-ly Md

Address Dec-ly Md Date signed 5/24/46

RECEIVED

MAY 30 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

## CERTIFICATE OF DEATH

Reg. Dist. No. 337

05245

## 1. PLACE OF DEATH:

County WicomicoCity or town White Haven  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County WicomicoCity or town White Haven  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Evelyn Washfield

## 3. (b) Social Security Number

4. Sex 7 5. Color or race col 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife George Washfield7. Birth date of deceased (mo., day, yr.) Feb. 4 - 1894 6. (c) If alive, give age 52 years8. AGE: Years 52 Months 3 Days 19 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace White Haven, Wicomico, Md.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name Bernigson Conway13. Birthplace White Haven, Md.14. Maiden name Ellen Wallace15. Birthplace White Haven, Md.16. Informant Wesley WashfieldAddress White Haven, Md.17. Burial Date thereof 5/30/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Burials Cem. Clara MdLocation near messicks store18. Funeral director ThessieAddress Bwalbe, Md.19. May 30 1946 R. Washfield Waller  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1946, at 11:25 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 1946, to May 27 1946.and that I last saw her alive on May 24 1946

Immediate cause of death \_\_\_\_\_ DURATION

Pulmonary tuberculosis 6 PM

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Gerne G. Mavis M. D. or otherAddress Princess Anne Date signed May 28 '46

RECEIVED  
JUN 6 1946  
BUREAU OF



RECEIVED  
JUN 7 1946  
BUREAU V.E.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1760

05247

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Pittsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 hours

Hospital, institution, or street address where death occurred:

C. G. Hospital Salisbury, Md

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Pittsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Dennis, Thomas

## 3. (b) Social Security Number

219-C1-9639

## 4. Sex

male

## 5. Color or race

White

## 6. (c) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

## 7. Birth date of

deceased (mo., day, yr.)

May 5 / 1924

## 6. (c) If alive, give age. \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

2207

hrs.

min.

## 9. Birthplace

Pittsville, Wicomico, Md  
(Town, county, and state)

## 10. Usual occupation

Printer

## 11. Industry or business

William T. Dennis

## 12. Name

## 13. Birthplace

Maryland

## 14. Maiden name

Elva D. Dennis

## 15. Birthplace

Maryland

## 16. Informant

Mrs. Elva D. Dennis

## 17. (Burial, cremation, or removal. Which?)

Burial

## Date thereof

May 14 / 46  
(month) (day) (year)

## Cemetery or crematory

Pittsville, Md

## 18. Funeral director

Hearne + Dumps

## Address

Snow Hill, Md

## 19.

(Date rec'd by registrar)

6-7/461946Barrett E. Johnson

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 5-12 1946 at 4<sup>13</sup> 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 46 4 13 9 Mand that I last saw medical certificate alive on 19 46 4 13 9 M

## Immediate cause of death

Fractured Skull  
Fractured Left Humerus

## DURATION

4 hrs  
4 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide accident Date of 5/11/46Where did injury occur? Pittsville Wicomico Md  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HighwayMeans of injury auto accident Injured at work? No

23. SIGNATURE

Barrett E. Johnson M.D. or other  
Salisbury, Md Date signed 5/12/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 18 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

05248

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WilkesCity or town Salisbury md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 weeksHospital, institution, or street address where death occurred:  
Peninsula General HospitalHow long in hospital or institution? 4 weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County WilkesCity or town Berlin md  
(If outside city or town limits, write RURAL and give nearest town)Street No. no  
(If rural, give LOCATION)2.(a) If veteran, name war no

## 3. (a) FULL NAME

John Dickson

## 3. (b) Social Security Number

4. Sex Male 5. Color or race A.A. 6.(a) Single, married, widowed, or divorced Single6.(b) Name of husband or wife no7. Birth date of deceased (mo., day, yr.) about 19008. AGE: Years 45 Months about Days about If less than one day hrs. min.9. Birthplace Synauxtant md  
(Town, county, and state)10. Usual occupation laborer11. Industry or business same as above12. Name Edward Dickson13. Birthplace Berlin md14. Maiden name Phyllis Davis15. Birthplace Synauxtant md16. Informant Phyllis DicksonAddress Berlin md17. Burial Date thereof May 10 - 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory familyLocation Synauxtant md19. Funeral director James H. StewartAddress Salisbury md19. 5-8 19 46 Charles E. Johnson Registrar

(Date received by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 6<sup>th</sup> 19 46 at 7<sup>00</sup> AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/7 19 46 to 5/6 19 46  
and that I last saw him alive on 5/6 19 46Immediate cause of death Chronic myocarditis DURATION several months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles E. Johnson M. D. or otherAddress Salisbury md Date signed 5/7/46

RECEIVED

MAY 10 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

05249

333

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 Day  
 Hospital, Institution, or street address where death occurred:  
Peninsula General Hospital  
 How long in hospital or institution? 1 Day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester  
 City or town Snow Hill  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Ruth Virginia Drumgo

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife \_\_\_\_\_  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) April 19 1946  
 8. AGE: Years \_\_\_\_\_ Months I Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Snow Hill Worcester Maryland  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

FATHER 12. Name Kearney D Drumgo  
 13. Birthplace North Carolina  
 MOTHER 14. Maiden name Ruth V Wise  
 15. Birthplace Virginia

16. Informant Ruth V Wise  
 Address Snow Hill Maryland

17. Burial Baptist Date thereof May 22 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or ~~cemetery~~ Baptist  
 Location Snow Hill Maryland

18. Funeral director Hearne & Dennis  
 Address Snow Hill Md

19. 5/24/46 Harriet L. Johnson  
 (Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1946 at 3:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/18/46 1946 to 5/21/46 1946  
 and that I last saw her alive on 5/21/46 1946

Immediate cause of death

Broncho pneumonia

DURATION

3 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

Paul Owen M.D.  
 Address Snow Hill Date signed 5/22/46

RECEIVED  
MAY 28 1946  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 14212

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH

County SalisburyCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 yearsHospital, institution, or street address where death occurred: P.S. Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. 418 Washington St  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Essie Esham

## 3. (b) Social Security Number

## 4. Sex

female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 8. (b) Name of husband or wife

Floyd E. Esham8. (c) If alive, give age 40 years

## 7. Birth date of deceased (mo., day, yr.)

Aug. 16 - 1906

## 8. AGE:

39 Years 8 Months 15 Days If less than one day  
..... hrs. .... min.

## 9. Birthplace

Chance md.  
(Town, county, and state)

## 10. Usual occupation

House wife

## 11. Industry or business

at home

## FATHER

12. Name John E. Boyman13. Birthplace Chance md.14. Maiden name May Horner15. Birthplace Chance md.16. Informant Mr. Floyd E. EshamAddress 418 Washington St. Salisbury Md17. Burial Date thereof May 4-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Nico. Mem. ParkLocation Salisbury md.18. Funeral director W.H. Spout & E. Walter R. HillmanAddress Salisbury md.19. 5-7-46 19 46

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 1st 19 46 at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-26 19 46 to 5-1 19 46and that I last saw her alive on 5-1-46 19 46Immediate cause of death uræmiaDue to Ectopic pregnancy

DURATION

Other conditions Chronic nephritiscalculus both kidneys

(Include pregnancy within 3 months of death)

Major findings of operations Ectopic pregnancyDate of op. 4-26-46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Injured at work?

23. SIGNATURE Floyd E. Esham

M. D. or other

Date signed 5-2-46

RECEIVED

MAY 9 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Mann

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

05251

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color of face

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Buried

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

46

Barrett E. Johnson

Local

Registrar

Address

Date signed

5/8/46

3/8/46

3/8/46

3/8/46

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3/8/46

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 7<sup>th</sup> 1946 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1946 to May 7 1946

and that I last saw him alive on May 5 1946

Immediate cause of death

Pulmonary Tuberculosis

DURATION

4 yr 2 mo

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed

RECEIVED

MAY 15 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. ~~M~~

Dr. Radmacker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-e

# CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH: *Mcconnis*  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
*P.O. (Ocean City Road)*  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State.....*Del.* County.....*Sussex*  
City or town.....*Bethel*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2 (a) If veteran, name war.....

3. (a) FULL NAME *Arthur Linwood Fitzguald* 3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Single*

6. (b) Name of husband or wife  
6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) *June 16 - 1919*

8. AGE: Years *24* Months *10* Days *15* If less than one day..... hrs. .... min.

9. Birthplace *P.O. Laurel Delaware*  
(Town, county, and state)

10. Usual occupation *None*

11. Industry or business

12. Name *Barland Fitzguald*

13. Birthplace *Prince Anne, Md.*

14. Maiden name *Amanda Lewis*

15. Birthplace *Bircher, Md.*

16. Informant *Mr. Amanda Fitzguald*  
Address *Bethel Delaware*

17. *Burial* Date thereof *May 6 - 46*  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory *Mt. Zion Cem.*  
Location *Laurel + Maple Road*  
*near Laurel Del.*

18. Funeral Director *Walter R. Holloway*  
Address *Salisbury Md.*

19. *5-16-46* (Date received by registrar) Registrar *Barriett L. Johnson*

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 1<sup>st</sup> 1946*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *death* and that I last saw him *on* *accident report* *19*

Immediate cause of death *traused skull & brain*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death) *None*

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of *May 1, 1946*  
Where did injury occur? *New Salisbury* (City or town) *Worcester* (County) *Md.* (State)  
Injured at home, farm, industry, public place (where?) *Highway*  
Means of injury *car skidded &* Injured at work? *No*

23. SIGNATURE.....  
Date signed *5/2/46*

RECEIVED

MAY 9 1946

BUREAU V.S.

ARTESIAN WIGER

ARTESIAN WIGER

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Lynch

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

## CERTIFICATE OF DEATH

05253  
Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County SalisburyCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 yearsHospital, institution, or street address where death occurred:  
R.O. #3

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Md. County McCombsCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. R.O. #3  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Gonar Henry Hampshire

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Dora L. Hampshire

7. Birth date of

deceased (mo., day, yr.) Dec. 30 - 18566. (c) If alive, give age Dead years

8. AGE:

Years

Months

Days

If less than one day

8946

hrs.

min.

9. Birthplace

Seneca Co. Ohio  
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Farm

FATHER

12. Name

George Hampshire

13. Birthplace

Ohio

MOTHER

14. Maiden name

Nancy Foster

15. Birthplace

Ohio

16. Informant

Mr. Roger H. Hampshire

Address

R.O. #3 Salisbury Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereon

May 9-46

(month) (day) (year)

Cemetery or crematory

McCombs Mem. Park

Location

Salisbury Md.

18. Funeral director

Hillman & Co. Walter R. Hillman

Address

Salisbury Md.

19.

(Date received by registrar)

5/9/46Barrie E. Johnson

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 6<sup>th</sup> 1946

at

3109

I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 6<sup>th</sup> 1946 to May 6<sup>th</sup> 1946and that I last saw him alive on May 6<sup>th</sup> 1946

Immediate cause of death

Heart dilatation

DURATION

of heart3 hours

Due to

Chronic myocardiopathy6 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. Lynch

M. D. or other

Address Salisbury Md. Date signed May 7/46

MAY 11 1946  
BUREAU V. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05254

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH

County..... EdenCity or town..... Eden P.O. #2  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 9 yearsHospital, institution or street address where death occurred:  
P.O. #2

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State..... Md. County..... McCombsCity or town..... Eden  
(If outside city or town limits, write RURAL and give nearest town)Street No. .... P.O. #2  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Mary Frances Harrington

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widow

## 6. (b) Name of husband or wife

John Thomas Harrington

8. (c) If alive, give age..... years

## 7. Birth date of deceased (mo., day, yr.)

May 27-1868

## 8. AGE:

Years..... 77 Months..... 11 Days..... 27 If less than one day..... hrs. .... min.

## 9. Birthplace

Birch, Maryland  
(Town, county, and state)

## 10. Usual occupation

Home life

## 11. Industry or business

at home

## MOTHER

## 12. Name

John R. Harrington

## 13. Birthplace

Birch, Md.

## 14. Maiden name

Sallie Moore

## 15. Birthplace

Birch, Maryland

## 16. Informant

Mr. Omar Harrington

## Address

and Mrs. Paul Taylor P.O. #2 Eden

## 17. Burial

May 27-46  
(Burial, cremation, or removal. Which?)

## Cemetery or crematory

Birch Church Cem.

## Location

Birch, Maryland

## 18. Funeral director

Holloway & Co. Walter R. Holloway

## Address

Sallie, Maryland

## 19.

6-24-46  
(Date read by registrar)

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

May 24 1946 3:30 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from

May 23, 1946 to May 24, 1946and that I last saw him or her alive on May 23, 1946

## Immediate cause of death

Uremia

## DURATION

## Due to

Intermittent C-V-R

## Due to

Uremia

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. ....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

John W. Gray, M.D.

M. D. or other

Address

Date signed

5/24/46

RECEIVED  
MAY 28 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

## CERTIFICATE OF DEATH

Reg. Dist. No. 5255 333

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 84 Years  
 Hospital, institution, or street address where death occurred:  
230 Newton, St  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 230 Newton St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Elizabeth Ellen Harvey

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife James E. Harvey  
 7. Birth date of deceased (mo., day, yr.) Nov. 1, 1861 6.(c) If alive, give age 87 years  
 8. AGE: Years 84 Months 6 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Salisbury, Wicomico, Co., Md  
 (Town, county, and state)  
 10. Usual occupation At Home  
 11. Industry or business

**FATHER**  
 12. Name James E. Mitchell  
 13. Birthplace Wicomico, Co., Md  
**MOTHER**  
 14. Maiden name Priscilla F. Stemons  
 15. Birthplace Somerset, Co., Md  
 16. Informant J. Edgar Harvey  
 Address Salisbury, Md  
 17. Burial Date thereof 5 / 7 / 46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Parsons Cemetery  
 Location Salisbury, Md  
 18. Funeral director The Hill & Johnson Co.  
 Address Salisbury, Md  
 19. 5-7-46 19 46  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 19 46 4:45 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 46 to May 4 46and that I last saw him alive on May 1 19 46Immediate cause of death Cerebral hemorrhage DURATION 42mDue to chronic myocarditis ?Due to arteriosclerosis ?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. or otherAddress Salisbury Date signed May 5 46

RECEIVED

MAY 11 1946

BUREAU V S

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05256

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Fruitland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 33 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Fruitland  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Leland R. Hobbs

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6.(a) Single, married, widowed, or divorced \_\_\_\_\_

Male White Married6.(b) Name of husband or wife Carrie V. Hobbs7. Birth date of deceased (mo., day, yr.) Dec. 15, 1891  
6.(c) If alive, give age 56 years8. AGE: Years 54 Months 4 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Fruitland, Wicomico, Co. Md  
(Town, county, and state)10. Usual occupation Machinist Foreman11. Industry or business Planing Mill12. Name Peter J. Hobbs13. Birthplace Wicomico, Co Md14. Maiden name Ester J. Hayman15. Birthplace Wicomico, Co. Md16. Informant Mrs. Leland HobbsAddress Fruitland, Md17. Burial Date May 3 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Methodist CemeteryLocation Fruitland, Md18. Funeral director The Hill & Johnson Co.Address Salisbury, Md19. 67/9 19 46 May 3 1946  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH May, 1, 1946 530A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

end that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Myocardial Infarction

DURATION

3 wkDue to Arterio Sclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE L. L. Lundy, M.D.  
M. D. or other \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

MARGIN RESERVED FOR BINDING

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 11 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05257

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

General

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Feb. 12, 1946.

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

314

hrs.

min.

9. Birthplace

Salisbury Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Calvin P. Hudson  
Md.

13. Birthplace

MOTHER

14. Maiden name

Evelyn V. Wilkerson  
Md.

15. Birthplace

16. Informant

Address

Calvin Hudson  
Bishop Md. RFD

17. Burial

(Burial, cremation, or removal. Where?)

Date thereof

May 28 1946  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

Bishopville, Md.  
M. Pasha Watson  
Salisbury, Del.

19.

(Date rec'd by Registrar)

19

46

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Worcester

City or town

Bishop P.Fd  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

26 May

19

46 at 3:20 a.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

25 May

19

46

to

26 May 19 46

and that I last saw him alive on

25 May

19

46

Immediate cause of death

Pneumonia

DURATION

1 wk.

Due to

Type undetermined

Due to

Other conditions

Acute naso-pharyngitis 1 wk.

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. W. D.

M. D. or other

Address

Salisbury Md. Date signed 26 May 46

CERTIFICATE OF DEATH

STATE OF NEW YORK

STATE OF NEW YORK

DEPARTMENT OF HEALTH

RECEIVED  
MAY 30 1946  
BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 154

## CERTIFICATE OF DEATH

05258

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Simmons Memorial Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County WorcesterCity or town Girdletrees  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Jester

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

W

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

2 hrs. 15 min.

9. Birthplace

Salisbury, Wicomico Co., Md.  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

FATHER  
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address \_\_\_\_\_

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Crematory or crematory

Location

18. Funeral director

Address \_\_\_\_\_

19.

6/28/1946  
(Date rec'd by registrar)

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## MEDICAL CERTIFICATION

20. DATE OF DEATH May 28/46 19 46, at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Salisbury, Md. Date signed 5-26-46

RECEIVED

MAY 30 1946

BUREAU T 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-6

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town allen  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County WicomicoCity or town allen  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Bessie B King

## 3. (b) Social Security Number

4. Sex Female 5. Color or race col 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Earnest King7. Birth date of deceased (mo., day, yr.) June 11-1881 6. (c) If alive, give age 68 years8. AGE: Years 61 Months 6 Days 11 If less than one day 16 hrs. \_\_\_\_\_ min.9. Birthplace Baltimore md  
(Town, county, and state)10. Usual occupation House work

## 11. Industry or business

12. Name unknown

13. Birthplace \_\_\_\_\_

14. Maiden name unknown

15. Birthplace \_\_\_\_\_

16. Informant Earnest KingAddress Cadler R F D 8 md17. burial Date thereof May 30-1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory SalsburgLocation Salsburg md18. Funeral director Chas H WardAddress Marion md19. 6/28 19 46 Harriet E. Johnson  
(Date signed by registrar) (year) (month) (day) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 19 46, at 4:15 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15, 19 45 to May 27, 19 46 and that I last saw her alive on May 20, 19 46.

Immediate cause of death

DURATION

Carcinoma of stomach year

Due to

Due to

Other conditions

Hypertension2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ injured at work? \_\_\_\_\_

23. SIGNATURE

G. Herbert Semble MDM. D. 6/27/46Address Salisbury Md Date signed 6/27/46

RECEIVED

JUN 1 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**MARYLAND STATE DEPARTMENT OF HEALTH**

2411 N. Charles St., Baltimore

49-0

05260

# CERTIFICATE OF DEATH

★ Reg. Diat. No. 333

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
County..... <u>Frederick</u>				State..... <u>MD</u> County..... <u>Frederick</u>			
City or town..... <u>Frederick</u> (If outside city or town limits, write RURAL and give nearest town)				City or town..... <u>Frederick</u> (If outside city or town limits, write RURAL and give nearest town)			
How long in above place of death?..... <u>24 years</u>				Street No..... <u>1100 N. 1st</u> (If rural, give LOCATION)			
Hospital, institution, or street address where death occurred..... <u>Home</u>				2.(a) If veteran, name war.....			
How long in hospital or institution?.....				3.(b) Social Security Number.....			
3.(a) FULL NAME..... <u>Lydia Mae Kuyawa</u>				3.(b) Social Security Number.....			
4. Sex..... <u>Female</u>		5. Color of race..... <u>White</u>		6.(a) Single, married, widowed, or divorced..... <u>Married</u>		MEDICAL CERTIFICATION	
6.(b) Name of husband or wife..... <u>John G. Kuyawa</u>		6.(c) If alive, give age..... <u>65</u> years		2D. DATE OF DEATH..... <u>May 21</u> 19 <u>46</u> at..... <u>9:40</u>		21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... <u>January 1, 1946</u> to..... <u>May 21, 1946</u>	
7. Birth date of deceased (mo., day, yr.)..... <u>Sept. 17-1879</u>		8. AGE: Years..... <u>66</u> Months..... <u>8</u> Days..... <u>4</u> If less than one day..... hrs..... min.....		Immediate cause of death..... <u>Pulmonary Metastasis</u>		DURATION..... <u>?</u>	
9. Birthplace..... <u>P.O. Pontolite Md.</u>		10. Usual occupation..... <u>Home wife</u>		Due to..... <u>Carcinoma of Ovaries</u>		DURATION..... <u>?</u>	
11. Industry or business..... <u>at home</u>		12. Name..... <u>George E. Kuyawa</u>		Other conditions.....		(Include pregnancy within 3 months of death)	
13. Birthplace..... <u>P.O. Pontolite Md.</u>		14. Maiden name..... <u>Matilda Smith</u>		Major findings of operations.....		Date of op.....	
15. Birthplace..... <u>P.O. Pontolite Md.</u>		16. Informant..... <u>Mr. John G. Kuyawa</u>		Autopsy results.....		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
Address..... <u>Div. St. Frederick Maryland</u>		17. Burial..... <u>May 23-46</u>		22. VIOLENCE: If death was due to external causes, fill in the following:		Accident, suicide, or homicide..... Date of.....	
Cemetery or crematory..... <u>St. Mary's</u>		Location..... <u>Salisbury Maryland</u>		Where did injury occur?..... (City or town)..... (County)..... (State).....		Injured at home, farm, industry, public place (where?).....	
18. Funeral director..... <u>St. Mary's</u>		Address..... <u>Salisbury Maryland</u>		Injured at work?.....		Injured at work?.....	
19. Date read by registrar..... <u>5-10-46</u>		Registrar..... <u>Harriet G. Johnson</u>		23. SIGNATURE..... <u>John H. Johnson M.D.</u>		M. D. or other.....	
Address..... <u>238 Cambridge Ave</u>		Date signed..... <u>5-21-46</u>		Address.....		Date signed.....	

RECEIVED  
MAY 25 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

## CERTIFICATE OF DEATH

05261

★ Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

105 Cherry St  
How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. Maryland  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles Henry Larmore

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Mary Lizzie Larmore7. Birth date of deceased (mo., day, yr.) Aug 1, 1868  
6. (c) If alive, give age Dead years8. AGE: Years 77 Months 9 Days 8 If less than one day  
hrs. min.9. Birthplace Salisbury Md.  
(Town, county, and state)10. Usual occupation Retired Merchant11. Industry or business Retired12. Name Charles Wesley Larmore13. Birthplace Salisbury Md.14. Maiden name Parah Garrett15. Birthplace Salisbury Md.16. Informant Milton N. LarmoreAddress 1317 N. College Ave Salisbury Md17. Burial Date thereof May 10, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory SalisburyLocation Salisbury Md.18. Funeral director W. Glenn MessickAddress Garata Maryland19. 5-11, 46, Harriet E. Johnson  
(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 9th 1946 at 9:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1941 to May 9 1946  
and that I last saw h... alive on May 9 1946Immediate cause of death chronic myocarditis

## DURATION

4 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations no

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; no

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Radenmacher MD M. D. or otherAddress Salisbury, Md Date signed 5/11/46

RECEIVED

MAY 15 1946

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

832

05262

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH

County SalisburyCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 35 yearsHospital, institution, or street address where death occurred P.O. #3

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. P.O. #3  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Sarah Lulu Little

## 3. (b) Social Security Number

## 4. Sex

female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widow

## 6. (b) Name of husband or wife

Joseph E. LittleB. (c) If alive, give age deaf years

## 7. Birth date of deceased (mo., day, yr.)

May 10-1866

## 8. AGE:

Years

Months

Days

If less than one day

791121

hrs.

min.

## 9. Birthplace

Sturten C. Hammondport N.Y.  
(Town, county, and state)

## 10. Usual occupation

Home wife

## 11. Industry or business

at home

## 12. Name

Thomas Rice

## 13. Birthplace

Sturten C. N.Y.

## 14. Maiden name

Catharine Peabody

## 15. Birthplace

Sturten C. N.Y.

## 16. Informant

Mr. Edward E. Little

## Address

P.O. #3 Salisbury MD

## 17. Burial

Buried Date thereof May 4-46  
(Burial, cremation, or repository? (month) (day) (year))

## Cemetery or crematory

Palmer Ave

## Location

Salisbury MD.

## 18. Funeral director

Walter P. Hall

## Address

Salisbury MD.

## 19. (Date rec'd by registrar)

5/24/46Walter P. HallRegistrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 1st 1946 at 8:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 15-46 to May 1-46and that I last saw him alive on May 1-46

Immediate cause of death

Cerebral hemorrhage

DURATION

2 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Walter P. Hall

M. D. or other

Address

Salisbury MDDate signed 5/24/46

RECEIVED

MAY 9 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Gray

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05263

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County... *Salisbury*City or town... *Salisbury*  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *25 years*

Hospital, institution, or street address where death occurred

*706 7th St.*

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *Md.* County... *Wicomico*City or town... *Salisbury*  
(If outside city or town limits, write RURAL and give nearest town)Street No... *706 7th St.*

(If rural, give LOCATION)

2. (a) If veteran, name war...

## 3. (a) FULL NAME

*John Littleton Floyd*

## 3. (b) Social Security Number

4. Sex

*Male*

5. Color or race

*White*

6. (a) Single, married, widowed, or divorced

*Married*

6. (b) Name of husband or wife

*Bessie Mae Floyd*

7. Birth date of

deceased (mo., day, yr.)

*Oct. 19 - 1877*

6. (c) If alive, give age

*64 years*

8. AGE:

*68* Years *6* Months *15* Days If less than one day

9. Birthplace

*Kingston Md.*  
(Town, county, and state)

10. Usual occupation

*Blacksmith*

11. Industry or business

*John W. Floyd*

12. Name

*Samuel Co. Del.*

13. Birthplace

*Samuel E. Bloodworth*

14. Maiden name

*Fenton Md.*

15. Birthplace

*Mrs. Bessie M. Floyd*

16. Informant

*706 7th St. Salisbury Md.*

Address

*Buried*

17. (Burial, cremation, or removal. Which?)

*Parson*

Cemetery or crematory

*Salisbury Md.*

Location

*Hill & Co. Walter R. Hill*

18. Funeral director

*Salisbury Md.*

Address

*577, 1946*

19. (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*May 4 1946* at *110 P*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Dec 4* 19*45* to *May 4* 19*46*and that I last saw him alive on *April 30* 19*46*

Immediate cause of death

*Cardiac Decomp*Due to *arteriosclerotic heart**disease*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Injured at work?

23. SIGNATURE

*William D. Gray, M.D.*Address *Salisbury Md*Date signed *5/7/46*

RECEIVED

MAY 9 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

732

## CERTIFICATE OF DEATH

★ 05264

Reg. Dist. No. 333

1. PLACE OF DEATH: *McCombs*  
County *Salisbury*  
City or town *8 year*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
*203 Ohio Ave.*  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: *McCombs*  
(For newborn infants give residence of mother)  
State *MD* County *Salisbury*  
City or town *8 year*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *203 Ohio Ave.*  
(If rural, give LOCATION)  
2.(a) If veteran, name war

## 3. (a) FULL NAME

*Alton Benjamin Lynch*

## 3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6.(a) Single, married, widowed or divorced *Married*  
6.(b) Name of husband or wife *Sara R. Stuart Lynch*  
6.(c) If alive, give age *36* years  
7. Birth date of deceased (mo., day, yr.) *Jun. 15 - 1906*  
8. AGE: Years *40* Months *3* Days *20* If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
9. Birthplace *P.O. Laurel Del.*  
(Town, county, and state)  
10. Usual occupation *Salisbury at*  
11. Industry or business *Dept. Store*  
12. Name *Elisha G. Lynch*  
13. Birthplace *Laurel Co. Del.*  
14. Maiden name *Ida C.*  
15. Birthplace

16. Informant *Mrs. Sara R. Lynch*  
Address *203 Ohio Ave. Salisbury Md*  
17. Burial *May 8 - 1946*  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)  
Cemetery or crematory *Old Fellows Cem.*  
Location *Laurel Delaware*  
18. Funeral director *W. H. Gray & Co. Walter R. Hill*  
Address *Salisbury Maryland*  
19. *5-18-46*  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH *May 5<sup>th</sup>* 19 *46* at *2 P.M.*  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan* 19 *45* to *May 5* 19 *46*  
and that I last saw him alive on *April 28* 19 *46*  
Immediate cause of death *Coronary occlusion*  
Due to *Hypertensive C-V. Disease*  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE *William D. Gray, M.D.*  
Address *Salisbury, Md* Date signed *5/7/46*

RECEIVED

MAY 10 1946

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Brame

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 109

## CERTIFICATE OF DEATH

05265

Reg. Dist. No. 383

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date received by registrar)

1946

1946

1946

1946

25. SIGNATURE

M. D. or other

Address

Date signed

## MEDICAL CERTIFICATION

20. DATE OF DEATH

19

at

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

1946

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

25. SIGNATURE

M. D. or other

Address

Date signed

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

FOR CONTENT

RECEIVED  
MAY 15 1946  
BUREAU OF INVESTIGATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D1. No. 1

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (127-P)

05266

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County SalisburyCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?  
Hospital, institution or street address where death occurred:  
P.B. Hosp.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County NeonicsCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D. #3  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Annie Elizabeth Moore

## 3. (b) Social Security Number

4. Sex female5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife James Edward Moore7. Birth date of deceased (mo., day, yr.) March 14-18876. (c) If alive, give age 78 years8. AGE: Years 59 Months 1 Days 25 hrs. min.9. Birthplace Neonics C. Maryland  
(Town, county, and state)10. Usual occupation Home wife11. Industry or business at home12. Name Burton Phillips13. Birthplace Neonics C. Maryland14. Maiden name Laura Richardson15. Birthplace Neonics C. Maryland16. Informant Mr James E. MooreAddress R.D. #3 Salisbury Maryland17. Burial Burial Date thereof May 12-1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Bethel Church Cem.Location Neonics Maryland18. Funeral director Holloman & Co. Walter R. HollomanAddress Salisbury Maryland19. 6-11-46 Registrar Harriet G. Johnson

(Date read by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1946 at 12 noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/11 1946 to 5/9 1946and that I last saw him alive on 5/9 1946

Immediate cause of death

Self Bladder AneurDue to VDue to VOther conditions —

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. 4/16/46Autopsy results V

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. H. Phillips

M. D. or other

Address Salisbury Date signed 5/11/46

RECEIVED

MAY 15 1946

BUREAU V F

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05267

★ Reg. Dist. No. 337

1. PLACE OF DEATH: *McCombs*  
County *Salisbury*  
City or town *2 year*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, street address where death occurred:  
*399 E. Vine St.*  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State *MD* County *McCombs*  
City or town *Salisbury*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *399 E. Vine St.*  
(If rural, give LOCATION)  
2. (a) If veteran, name war

3. (a) FULL NAME *Marion Franklin Morris* 3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widowed*

6. (b) Name of husband or wife *Laura Morris*

7. Birth date of deceased (mo., day, yr.) *Oct. 7<sup>th</sup> 1882* (c) If alive, give age *Dead* years

8. AGE: Years *63* Months *7* Days *23* If less than one day  
hrs. min.

9. Birthplace *PO. Salisbury Md.*  
(Town, county, and state)

10. Usual occupation *Carpenter*

11. Industry or business *None*

12. Name *Rose Morris*

13. Birthplace *McCombs Co. Md.*

14. Maiden name *Susan Wachtman*

15. Birthplace *Eden Maryland*

16. (a) Date of death *June 1-1946*  
Address *217 E. Vine St. Salisbury Md.*

17. Burial, cremation, or removal, Which? *Burial* Date thereof (month) (day) (year)  
*Freemantle Md. Cem.*  
Cemetery or crematory *Freemantle Maryland*  
Location *Hillman & Co. Walter R. Hillman*

18. Funeral director *Salisbury Maryland*  
Address

MEDICAL CERTIFICATION  
20. DATE OF DEATH *May 30<sup>th</sup> 1946* at *7:55 PM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *May 29* 1946 to *May 30* 1946  
and that I last saw him alive on *May 30* 1946

Immediate cause of death *Metastatic Pulmonary*

Due to *Carcinoma of Prostate*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE *John H. Norman M.D.*  
Address *3 E. Camden Ave. Salisbury*  
Date signed *May 30, 1946*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY IN UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

informant  
Mrs. L. B. Hillman  
1813 Hillman St.

RECEIVED  
JUN 7 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Mann

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

05268

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 47 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 1 week

## 3. (a) FULL NAME

Margaret Patterson Murphy4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Geo. Washington Murphy7. Birth date of deceased (mo., day, yr.) Sept. 10 1873 6. (c) If alive, give age deceased years8. AGE: 72 Years Months Days If less than one day  
.....hrs. ....min.9. Birthplace Baltimore Md.  
(Town, county, and state)10. Usual occupation House work11. Industry or business at home12. Name William Perry Meale's13. Birthplace Baltimore Maryland.14. Maiden name Jennie Black15. Birthplace Belfast Ireland.16. Informant George C. MurphyAddress 200 New York Ave. Salisbury Md.17. (Burial, cremation, or removal. Which?) Burial Date thereof May 21 1946  
(month) (day) (year)Cemetery or crematory Parsons CemeteryLocation Salisbury Md.18. Funeral director Holloway & SonAddress 520 East Church St. Salisbury Md.19. 6-21-46 Registrar Harriet L. Johnson

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1001 E Church St  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1946 at 8:05 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1928 to May 19 1946and that I last saw him alive on May 19 1946Immediate cause of death Cardio-Vas-Neuropathic 20 yrs.

DURATION

Due to

Due to

Other conditions Cystic Hydatid

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John R. Mann

M. D. or other

Address Salisbury Md. Date signed 3/29/46

RECEIVED

MAY 24 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

## CERTIFICATE OF DEATH

05269

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WilkesCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 1/2 hr.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County WilkesCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. Rt. #1  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Payne-Baby Girl

## 3. (b) Social Security Number

4. Sex

Female white

5. Color or race

6. Single, married, widowed, or divorced

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

1/2 hrs. .... min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name.....

13. Birthplace.....

MOTHER

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17.

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cremation or crematory.....

Location.....

18. Funeral director.....

Address.....

19.

(Date read by registrar)

19. 46

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 19 46 at 2:25 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where and injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed 5-13-46

RECEIVED

MAY 18 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

## CERTIFICATE OF DEATH

Reg. Dist. No. 05270 333

## 1. PLACE OF DEATH:

County.....Wicomico.....City or town.....Salisbury.....  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?.....East Fork Wicomico River.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md..... County.....Wicomico.....City or town.....Siloam.....  
(If outside city or town limits, write RURAL and give nearest town)Street No.....Salisbury R. D. I.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Bobby Lee Potts

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

July, 14, 1931

6. (c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

14106

.....hrs.

.....min.

9. Birthplace.....

Siloam, Wicomico Co., Md  
(Town, county, and state)

10. Usual occupation.....

School Boy

11. Industry or business.....

FATHER  
MOTHER12. Name.....Ellis Jarnon Potts13. Birthplace.....Artemas, Penna.14. Maiden name.....Pauline Malone15. Birthplace.....Wicomico, Co. Md16. Informant.....Ellis C. Potts

Address

Salisbury, Md.17. Burial.....  
(Burial, cremation, or removal. Which?)Date there.....5/23/46

(month) (day) (year)

Cemetery or crematory.....Wicomico Memorial ParkLocation.....Salisbury, Md18. Funeral director.....The Hill & Johnson Co.

Address

Salisbury, Md

19.

5-20-46  
(Date rec'd by registrar)19. 4619. 46

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....May, 20, 1946.....at 4 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him.....medical attention.....19.....

Immediate cause of death.....

Drowning

DURATION

suicide  
death

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

none

Date of op. ....

Autopsy results.....

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

accident

Date of.....

5-20-46Where did injury occur?.....Salisbury.....  
(City or town)Wicomico  
(County)Md  
(State)

Injured at home, farm, industry, public place (where?).....

Public Park

Means of injury.....

slept in hole in

Injured at work?.....

no

23. SIGNATURE.....

LaRadenalby  
Registrar

M. D. or other

Address.....

Salisbury, MdDate signed.....5/24/46

RECEIVED

MAY 28 1946

BUREAU VE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Mardela Springs - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
San Domingo  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico  
 City or town Mardela Springs - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. San Domingo  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Minerva E. Quinton

## 3. (b) Social Security Number

219-07-7912

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife  
 6. (c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) September 10, 1909  
 8. AGE: Years 36 Months 7 Days 21 If less than one day ..... hrs. .... min.

9. Birthplace Wicomico County, Maryland  
 (Town, county, and state)  
 10. Usual occupation Housework  
 11. Industry or business Home  
 FATHER  
 12. Name Ernest Quinton  
 13. Birthplace Wicomico County, Maryland  
 MOTHER  
 14. Maiden name Annie Cornish  
 15. Birthplace Wicomico County, Maryland

16. Informant Mrs. Annie Quinton  
 Address Mardela Springs, Maryland, R.F.D.  
 17. Burial Date thereof May 6, 1946  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory San Domingo Cemetery  
 Location Near Sharptown, Maryland  
 18. Funeral director J. J. Frampton and Son  
 Address Federalburg, Maryland  
 19. May 6 19 46 J. J. Frampton  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 19 46, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 19 46 to May 1 19 46  
 and that I last saw him alive on May 1 19 46

Immediate cause of death ..... DURATION  
Carcinoma of Throat 9-12 mo.  
 Due to .....  
 Due to .....  
 Other conditions .....  
 (Include pregnancy within 8 months of death)

Major findings of operations ..... Date of op. ....  
 Autopsy results .....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ..... Date of .....  
 Where did injury occur? ..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) .....  
 Means of injury ..... Injured at work?

23. SIGNATURE Harvard T. Well, M.D. M. D. or other  
 Address Easton, Md. Date signed 5/5/46

RECEIVED  
MAY 28 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-6

## CERTIFICATE OF DEATH

05272

Reg. Dist. No. 339

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex.....

5. Color or race.....

6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

10. Usual occupation.....

11. Industry or business.....

FATHER  
MOTHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetary or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar)

19. 46. Registrar

Registrar

Address.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

19. 46. at

5. P. M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

to

19.....

and that I last saw him..... alive on

19.....

Immediate cause of death.....

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

21. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Injured at work?

23. SIGNATURE.....

M. D. or other

Date signed.....

RECEIVED

MAY 15 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Wilcomica  
 City or town Millard, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 57 years  
 Hospital, institution, or street address where death occurred: no  
 How long in hospital or institution? no

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County Wilcomica  
 City or town Millard, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. no  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war no

## 3. (a) FULL NAME

Alice Smith

## 3. (b) Social Security Number

no

4. Sex female 5. Color or race a.a. 6. (a) Single, married, widowed, or divorced widow

8. (b) Name of husband or wife no

7. Birth date of deceased (mo., day, yr.) Dead 8. (c) If alive, give age no years

11. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 62 Months — Days — If less than one day — hrs. — min.

9. Birthplace Snawhill (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Same as above

12. Name Edward Smith

13. Birthplace Parsonsburg, Md

14. Maiden name Elizabeth Dale

15. Birthplace Snawhill, Md

16. Informant Allen Hudson

Address Salisbury, Md

17. Burial (Burial, cremation, or removal, which) Burial Date thereof May 26-1946

(month) (day) (year)

Cemetery or crematory Glory Hill

Location Parsonsburg, Md

18. Funeral director James Stewart

Address Salisbury, Md

19. (Date rec'd by registrar) 5/24/46 Registrar Barrie P. Johnson

Address Salisbury, Md Date signed 5/23/46

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 19 46 at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19, 19 46 to May 22, 19 46

and that I last saw her alive on May 20, 19 46

Immediate cause of death Cerebral Apoplexy 3 days

Myocarditis 44 years

Hypertension 5 years

Diabetes year

Other conditions Diabetic Gangrene 1 mo.

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE E. J. Seubley, M.D.

Address Salisbury, Md Date signed 5/23/46

RECEIVED

MAY 28 1946

BUREAU V. E.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

### 1. PLACE OF DEATH:

County Wicomico  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 days  
Hospital, institution, or street address where death occurred: Salisbury Sanitarium  
How long in hospital or institution? —

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Worcester  
City or town Newark (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. —  
(If rural, give LOCATION)  
2. (a) If veteran, name war —

### 3. (a) FULL NAME

William Franklin Smith

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Connie Belle Smith  
6. (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) July 3, 1865

8. AGE: Years 80 Months 10 Days 18 hrs. — min.

9. Birthplace Millboro Sussex Delaware  
(Town, county, and state)

10. Usual occupation waterman

### 11. Industry or business

12. Name James F. Smith  
13. Birthplace Delaware

14. Maiden name Jane Blaggard  
15. Birthplace New Jersey

16. Informant Charles D. Smith  
Address Rural Pocomoke Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof May 24, 1946  
(month) (day) (year)

Cemetery or crematory Bethany M. P. Cemetery  
Location Pocomoke Md.

18. Funeral director Thompson & Dutton  
Address Pocomoke Md.

19. 5-23-46 19. 46 Harriet E. Johnson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 19 46 at 9:40 A.M.

21. I CERTIFY that death occurred on the data above stated; that I attended deceased from May 10 19 46 to May 21 19 46 and that I last saw him alive on May 20 19 46

Immediate cause of death Coronary Thrombosis DURATION 2 wks

Due to hypertensive arterio-sclerotic heart disease unknown

Due to —

Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations — Date of op. —

Autopsy results —  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Paul Owen M.D. M. D. or other —  
Address — Date signed 5/21/46

MARGIN RESERVED FOR BINDING

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VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 24 1946  
BUREAU V &

Reg. Dist. No. 233

Address 1000 1st St. N. Minneapolis, Minn. Real Date closed 5/20/8

VS A15

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 28 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

05276  
Reg. Dist. No. 933

## 1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

## 3.(b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

B.(c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal) (Which?)

Date thereof

(month) (day) (year)

Cemetery or crematorium

Location

18. Funeral director

Address

19.

(Date read by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH

19. 46, at 1300

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1, 1945, to May 2, 1946

and that I last saw him alive on May 2, 1946

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 5/3/46

RECEIVED

MAY 9 1946

BUREAU V 8

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13720

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

### 1. PLACE OF DEATH:

County Accomack  
City or town Salisbury, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 16 days  
Hospital, institution, or street address where death occurred:  
Peninsula  
How long in hospital or institution? 16 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Virginia County Accomack  
City or town New Church  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Thomas Messels

### 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife Ella Florence Messels  
7. Birth date of deceased (mo., day, yr.) Oct 14 1884  
6.(c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 64 Months 6 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
9. Birthplace Mearsville, Va  
(Town, county, and state)  
10. Usual occupation farmer  
11. Industry or business \_\_\_\_\_

FATHER 12. Name Wm. Messels  
13. Birthplace Mearsville, Va  
MOTHER 14. Maiden name Caroline Justis  
15. Birthplace Nelsona, Va  
16. Informant Mrs. Thos. Messels  
Address New Church, Va  
17. Burial Burial Date thereof May 5 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Messels  
Location Mears, Va  
18. Funeral director W. S. Keith  
Address New Church, Va  
19. 6/4 19 46 Harris D. Johnson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1 19 46 at 5:52 M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/14 19 45 to 5/1 19 46  
and that I last saw him alive on 5/1 19 46  
Immediate cause of death Myocardial Infarction  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings of operations full  
Date of op. 4/20/45  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
23. SIGNATURE W. S. Keith M. D. or other \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 5/4/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 8 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

05278

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Worcester  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 24 hrs.  
 Hospital, institution, or street address where death occurred:  
120 David St. Salisbury  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Worcester  
 City or town Pocomoke City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rural, Eastern St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Annie White

## 3. (b) Social Security Number

4. Sex 7 5. Color or race C 6.(a) Single, married, widowed, or divorced Widowed

8.(b) Name of husband or wife Henry F. White

Deceased 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1874

8. AGE: Years 71 Months 6 Days 7 If less than one day  
 hrs. min.

9. Birthplace Pocomoke - Worcester - Md.  
 (Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

12. Name Julius Long13. Birthplace Bonux Co.14. Maiden name Mary Howard15. Birthplace Bonux Co.16. Informant Emil SterensonAddress 120 David St. Salisbury17. Burial Date thereof June 2, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pocomoke M.E. CemeteryLocation Rural Pocomoke, Md.18. Funeral director A. Harvey BroadshawAddress Crofton, Md.19. 6/30/46 Harriet E. Johnson

(Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 30, 1946 10:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6, 1946 to May 28, 1946and that I last saw him alive on May 28, 1946Immediate cause of death Chronic Myocarditis DURATION YearDue to Hypertension 5Due to Chronic Nephritis 24 yearsOther conditions Injury of Hip year

(Include pregnancy within 7 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of NoneWhere did injury occur? None (City or town) (County) (State)Injured at home, farm, industry, public place (where?) NoneMeans of injury None Injured at work? None23. SIGNATURE Harriet E. Johnson M.D. or otherAddress 608 E. Church St. Salisbury, Md. Date signed 5/30/46

RECEIVED

JUN 1 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 51 years  
 Hospital, institution, or street address where death occurred:  
Peninsula General Hospital  
 How long in hospital or institution? 1 week

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 118 E. Isabella  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Arthur Everett Williams

## 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Elizabeth D. Williams  
 6.(c) If alive, give age 52 years  
 7. Birth date of deceased (mo., day, yr.) Feb 8, 1891  
 8. AGE: Years 55 Months 2 Days 21 + hrs. min.  
 9. Birthplace Salisbury, Wicomico, Md  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business

FATHER 12. Name Sam Williams  
 13. Birthplace Wicomico, Md  
 MOTHER 14. Maiden name A. Blanch Astor  
 15. Birthplace Wicomico, Md  
 16. Informant Mr A. E. Williams  
 Address Salisbury Md  
 17. Burial Date thereof 5/6/46  
 (Burial, cremation, or removal) Which? (month) (day) (year)  
 Cemetery or crematory Parsons cemetery  
 Location Salisbury Md  
 18. Funeral director The Hill's Funeral Home  
 Address Salisbury Md  
 19. 5/6 19. 46 Registrar John J. Johnson  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 19. 46 at 5-40 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25 19. 46 to May 3 19. 46  
 and that I last saw him alive on May 3 19. 46  
 Immediate cause of death acute appendicitis + emboli  
 DURATION 1 day  
 Due to .....  
 Due to .....  
 Other conditions .....  
 (Include pregnancy within 3 months of death)  
 Major findings of operations None  
 Date of op. 5/24/46

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statitically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) .....  
 Means of injury ..... Injured at work?

23. SIGNATURE Dr. W. H. Johnson M. D. or other  
 Address Salisbury Md Date signed 5/15/46

RECEIVED

MAY 8 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-6)

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Wilcomica  
 City or town Prutland md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred: no  
 How long in hospital or institution? no

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Wilcomica  
 City or town Prutland md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. no  
 (If rural, give LOCATION) no  
 2(a) If veteran, name war no

## 3. (a) FULL NAME

Sarah M Wright

## 3. (b) Social Security Number

no

4. Sex female a.a. 5. Color or race Single 6. (a) Single, married, widowed, or divorced  
 6. (b) Name of husband or wife no 6. (c) If alive, give age no years  
 7. Birth date of deceased (mo., day, yr.) Aug 17 1929  
 8. AGE: Years 16 Months 8 Days 7 If less than one day  
 hrs. min.

9. Birthplace Prutland md  
 (Town, county, and state)

10. Usual occupation no

11. Industry or business no

FATHER 12. Name John Birnie

13. Birthplace Prutland md

MOTHER 14. Maiden name Marion Wright

15. Birthplace Prutland md

16. Informant Ellen Cannon

Address Prutland md

17. Burial Date thereof May 28 - 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory mt. Calvary

Location Prutland md

18. Funeral director James H. Stewart

Address Baltimore md

19. 6/4/46 19 46 Harriet E. Johnson Registrar  
 (Date read by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 19 46 at 4:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from live on to ex am certified 19

and that I last saw him live on ex am certified 19

Immediate cause of death Advanced Bilateral Pulmonary Tuberculosis

DURATION 6 mos

Due to no

Due to no

Other conditions no

(Include pregnancy within 3 months of death)

Major findings of operations none

none Date of op. no

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide. Date of no

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury La Rademaker MD Injured at work? no

23. SIGNATURE Deputy MD James M. D. or other no  
 Address Baltimore md Date signed 5/26/46

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JUN 7 1946

BUREAU V.E.